STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	R 12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The following citations represent the findings of a Non-compliance Revisit and Complaint investigation #KS000070890	{F 000}		
{F 314} SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This Requirement is not met as evidenced by: The facility identified a census of 34 residents. The sample included 8 residents. Based on observation, interview, and record review the facility failed to implement interventions to prevent the development of an unstageable pressure ulcer and a stage 2 pressure ulcer for 1 of 3 residents reviewed for pressure ulcers. (#20) Findings included: - Resident #20's significant change Minimum Data Set 3.0 Assessment (MDS) dated 10-3-13, documented the resident's Brief Interview for Mental Status score (BIMS) was 2, which indicated the resident had severe cognitive impairment. The MDS documented the resident was independent with bed mobility, toileting, and personal hygiene. The resident required extensive assistance with activities of daily living (ADLs) for ambulation and locomotion. The MDS documented the resident was continent of bowel	{F 314}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{F 314}	Continued From page 1 and bladder and had a stage I pressure ulcer. The MDS documented the resident resisted cares daily. The Pressure Ulcer Care Area Assessment (CAA) dated 10-3-13 documented the resident had a pressure relieving mattress on the bed, moved his/her heels up and down against the mattress and declined heel protectors. The resident insisted on staying in his/her room and stayed in bed most of the time. The resident developed skin breakdown because he/she insisted on laying in bed, rubbed his/her heels on the mattress and declined using heel protectors. The 10-30-13 Care Plan documented the resident had a stage I pressure ulcer on his/her right heel and had pain at times. The resident had an air mattress on the bed. The care plan directed staff to encourage the resident to use heel protectors and documented his/her refusal to wear them, apply skin prep (a solution that hardened the skin) to both heels, and keep the rails up to enable the resident to reposition and transfer his/herself. On 11-25-13 the care plan directed staff to apply an Allevyn (a dressing used on wounds that absorbed drainage and protect the wound) dressing to the resident's right heel. On 12-4-13 the care plan directed staff to apply Allevyn dressing to the resident's coccyx for his/her stage II pressure ulcer. The care plan lacked interventions to float the resident's heels or remind or prompt the resident to reposition. The 11-23-13 Braden scale (an assessment used to determine the risk of development of pressure ulcers) score 14 which indicated the resident had a moderate risk for the development of a pressure ulcer.	{F 314}		

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{F 314}	Continued From page 2 On 12-4-13 the nutrition note documented the resident's current weight of 158 and his/her weight in November 2012 was 166.8 pounds. The resident had a 5.1 percent (%) weight loss. The resident had a wound on his/her coccyx. The resident received a regular diet, took vitamin C and E and received ensure plus (a protein supplement) twice daily. The resident had a critically low pre Albumin (blood test used to determine nutritional status) and was at incresed nutritional risk due to his/her wound. The dietician recomended staff provide the resident with ensure three times daily and provide an multiple vitamin to improve skin integrity. On 11-25-13 at 11:05 A.M. a telephone order from the physician directed staff to place an Allevyn dressing to the resident's right heel and change it every 5 to 7 days and as needed. The physician prescribed Lortab (a narcotic pain medication) 5/325 milligrams (mg) every 6 hours as needed for pain. On 11-25-13 at 8:10 A.M. the nurse's note (NN) documented the resident complained of right heel pain and staff notified the physician. On 11-25-13 at 11:05 A.M. the NN documented the physician ordered pain medication and Allevyn dressing for the resident's right heel. On 11-30-13 with no time written, the NN documented the resident refused a shower and agreed to take it on 12-1-13. On 12-4-13 with no time written, the NN documented the resident with a stage 2 pressure ulcer on his/her coccyx and staff found it during the resident's shower.	{F 314}		

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{F 314}	Continued From page 3 On 12-4-13 at 3:15 P.M. per facsimile communication the facility notified the physician the resident had a stage II pressure ulcer that was a slit that measured 1 centimeter (cm). The physician ordered Allevyn dressing and directed staff to change the dressing every 5 to 7 days and as needed. Review of the nurses notes lacked evidence staff attempted further interventions to prevent the development of his/her pressure ulcers or provided education that explained the risk of the pressure ulcers worsening. Observation on 12-10-13 at 10:02 A.M. revealed the resident was in bed and his/her heels touched the mattress. The resident's eyes were closed and the resident did not respond to verbal greetings. The resident's bottom sheet was off of one corner of the bed. The resident had pressure reduction mattress on his/her bed. On 12-10-13 at 12:41 P.M. observation revealed the resident was in bed on his/her back and his/her heels were on the bed. The resident's eyes were closed and he/she did not respond to verbal greetings. The resident's bottom sheet was off of one corner on the bed. On 12-10-13 at 1:14 P.M. observation revealed the resident in bed and positioned on his/her back with his/her right knee bent with his/her foot on the mattress. The resident's eyes were closed and the resident did not respond to verbal greetings. The resident's lunch tray was on his/her over bed table and was untouched, and the bottom sheet was off of one corner of the bed.	{F 314}		

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{F 314}	Continued From page 4 On 12-10-13 at 4:24 P.M. observation revealed the resident in bed positioned on his/her back and his/her heels touched the mattress. The resident's eyes were closed and the resident did not respond to verbal greetings. The resident's bottom sheet was off on one corner of the bed. Observation on 12-11-13 at 2:41 P.M. revealed the resident was in bed, on his/her back. The resident's heels touched the mattress. The resident had his/her underwear on backwards and had a sock on his/her right foot. Licensed nurse H assisted the resident to a standing position and pulled down the resident's underwear. The resident had dried BM on his/her rectum, genitals and on his/her underwear. Licensed nurse H removed a dressing from the resident's coccyx dated 12-4-13 and the dressing had dried BM on it. The pressure ulcer was approximately 1 cm in length, 0.25 cm in width with no depth. The area was healing, had a whitish surface and the surrounding skin was intact. The resident also had dried BM on his/her bedding. Observation of the resident's right heel revealed Allevyn dressing on the heel dated 12-10-13. Licensed nurse H removed the dressing revealing an unstageable pressure ulcer that was dark brown in color and approximately 4 to 5 cm in length and 3 to 4 cm in width. The skin was intact. The resident's heels were laying on the bed. At this time the resident complained that his/her right heel hurt. Licensed nurse asked the resident if he/she wanted a pillow under his/her heel and the resident stated it made it worse. On 12-10-13 at 4:26 P.M. direct care staff O stated the resident did not allow staff to provide cares for him/her very often and refused cares frequently. He/she stated staff bribed the resident to take showers, and the resident did not	{F 314}		

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{F 314}	Continued From page 5 come out of his/her room very often. He/she stated the resident was continent of bowel and bladder, went to the bathroom independently and he/she was not aware if the resident currently had pressure ulcers. Direct care staff O stated the resident had some areas on his/her heels and staff attempted to use heel protectors but the resident refused them. On 12-11-13 at 3:59 P.M. direct care staff P stated staff checked on the resident every 2 hours and if the resident was asleep, they did not bother him/her. He/she stated the resident used his/her call light when he/she wanted something such as a pain pill or for staff to remove his/her meal tray. On 12-11-13 at 12:41 P.M. during interview, licensed nurse H stated he/she did not measure the area to the resident's heel and did not document it on a wound sheet. He/she stated the resident received skin prep on the heel and staff placed an Allevyn on it for protection because the resident refused a pillow to float his/her heels and refused to wear heel protectors. Licensed nurse H stated the resident developed a stage II pressure ulcer on his/her coccyx, documented it on the wound sheet and measured it weekly. Upon reviewing the wound sheet, licensed nurse H documented on 12-4-13 the pressure ulcer measured 1 centimeter (cm) in length without any drainage. The wound sheet lacked any further documentation. Licensed staff H stated he/she measured the wound weekly. On 12-12-13 at approximately 2:30 P.M. administrative nurse H stated the nurse measured the wounds weekly and the nurses assessed each resident head to toe weekly.	{F 314}		

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{F 314}	Continued From page 6 The October 2010 facility provided Prevention of Pressure Ulcers Policy and Procedure documented staff routinely assessed and documented the condition of the residents skin and reported any signs of a developing pressure ulcer to the charge nurse. The clinical record lacked evidence the facility timely assessed and provided effective interventions for the prevention and treatment of two unavoidable pressure ulcers.	{F 314}		
{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: The facility identified a census of 34 residents. The sample included 10 residents. Based on observation, interview, and record review the facility failed to provide care following a bowel movement (BM) for one of three residents observed for incontinence. (#20) Findings included: - Resident #20's significant change Minimum Data Set 3.0 Assessment (MDS) dated 10-3-13, documented the resident's Brief Interview for Mental Status score (BIMS) was 2, which	{F 315}		

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{F 315}	Continued From page 7 indicated the resident had severe cognitive impairment. The MDS documented the resident was independent with bed mobility, toileting, personal hygiene. The resident required extensive assistance with activities of daily living (ADLs) for ambulation,and locomotion. The MDS documented the resident was continent of bowel and bladder. The Incontinence Care Area Assessment (CAA) did not trigger. The 10-30-13 Care Plan directed staff to offer the resident a bath pack on bath days to wash him/herself if he/she declined a bath. Observation on 12-10-13 at 10:02 A.M. revealed the resident was in bed and lying on his/her back on his/her bed. The resident's eyes were closed and did not respond to verbal greetings. The resident's bottom sheet was off of one corner of the bed. On 12-10-13 at 12:41 P.M. observation revealed the resident was in bed and lying on his/her back in his/her bed. The resident's eyes were closed and he/she did not respond to verbal greetings. The resident's bottom sheet was off of one corner on the bed. The resident's pills were in a container on the resident's over bed table. On 12-10-13 at 1:14 P.M. observation revealed the resident was lying in bed on his/her back with his/her right knee bent. The resident's eyes were closed and the resident did not respond to verbal greetings. The resident's lunch tray was on his/her over bed table and was untouched, and the bottom sheet was off of one corner of the bed.	{F 315}		

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{F 315}	Continued From page 8 On 12-10-13 at 4:24 P.M. observation revealed the resident in bed with his/her eyes closed and did not respond to verbal greetings. The resident's bottom sheet was off on one corner of the bed. Observation on 12-11-13 at 2:41 P.M. revealed the resident was in bed and lying on his/her back. The resident had his/her underwear on backwards and had a sock on his/her right foot. Licensed nurse H assisted the resident to a standing position and pulled down the resident's underwear. The resident had dried BM on his/her rectum and in his/her underwear. Licensed nurse H removed a dressing from the resident's coccyx and the dressing had dried BM on it. The resident also had dried BM on his/her bedding. Observation of the linens hanging in the residents bathroom, had dried BM on the wash cloth and towel. Licensed nurse H removed the wet wipes from a container to cleanse the resident and the wet wipes were dry. Licensed nurse H put clean underwear on the resident and picked his/her sock up of the floor to place it on the resident and stated it was wet On 12-10-13 at 4:26 P.M. during staff interview, direct care staff stated the resident did not allow staff to provide cares for him/her very often and refused cares frequently. He/she stated staff had to bribe the resident to take showers, and did not come out of his/her room very often. He/she stated the resident was continent of bowel and bladder and went to the bathroom independently. On 12-11-13 at 3:59 P.M. during staff interview, direct care staff P stated they checked on the resident every 2 hours and if the resident was asleep, they did not bother him/her. He/she stated the resident used his/her call light when	{F 315}		

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{F 315}	Continued From page 9 he/she wanted something such as a pain pill or to remove his/her meal tray. On 12-11-13 at 4:25 P.M. during staff interview, direct care staff Q stated that they offered the resident showers, but he/she refused. Direct care staff Q stated if the resident refused, they would offer a different day and he/she typically agreed to shower. He/she stated that housekeeping informed the staff when the resident had BMs because he/she usually make a mess. He/she stated the resident used his call light for certain things but did not use his/her call light for toileting because he/she was independent. On 12-11-13 at 12:41 P.M. during interview, licensed nurse H stated the resident was independent with toileting and was continent of bowel and bladder. The facility failed to monitor toileting for this resident who staff identified as independent with toileting.	{F 315}		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility identified a census of 34 residents. The sample included 10 residents. Based on observation, interview, and record review the	{F 323}		

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{F 323}	Continued From page 10 facility failed to prevent resident #46 from leaving the facility without staffs knowledge. Findings included: - Resident #46's admission Minimum Data Set 3.0 Assessment (MDS) dated 12-10-13 documented the resident's Brief Interview for Mental Status score (BIMS) was 0, which indicated the resident had severe cognitive impairment. The resident had physical behaviors toward staff and others that put him/her at risk for injury. The resident wandered daily and was at risk for getting into dangerous places, intruded on the privacy of others, and was independent with ambulation. The Cognition Care Area Assessment (CAA) dated 12-10-13 documented the resident had poor short-term memory, unable to remember location of his/her room, and wandered in and out of peers rooms. The Falls CAA dated 12-10-13 documented the resident urinated in inappropriate places and wet on the floor which endangered him/herself and peers. The admission Care Plan dated 11-26-13 documented the resident as an elopement risk and directed staff to monitor the exit alarms, provide every 15 minute safety checks, document behaviors in the behavior monitoring log, place stop signs at all the exit doors, place the resident's photograph on the elopement risk board, and made staff aware the resident was at risk for elopement. On 11-26-13 the care plan documented the resident eloped out of the facility alone, returned uninjured and staff provided one on one observation and documented the	{F 323}		

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{F 323}	Continued From page 11	{F 323}		

resident's where about's every 15 minutes. On 11-27-13 staff changed the resident's room so it was closer to the nurses station. On 12-8-13 the care plan documented the resident toileted in inappropriate places such as the floor in other residents' rooms and in trash cans. The care plan directed staff to toilet the resident every one and a half to two hours. On 12-9-13 the care plan documented the resident hollered at another resident twice, so staff moved the other resident to a different hall.

The 12-10-13 Behavior Risk Assessment documented the resident paced and had aimless wandering constantly back and forth with no purposeful walking, had verbal aggression and eloped the first day of admission to the facility.

On 11-26-13 at 1:00 P.M. the nurse's note (NN) documented the resident arrived at the facility with family. The resident was alert and oriented to self.

On 11-26-13 at 2:45 P.M. the NN documented the resident eloped from the facility through the Assisted Living door. Staff found the resident across the street. The resident had shoes, socks, slacks, and a long sleeve shirt on. Staff assessed the resident's vital signs. The resident's ears, cheeks, and hands were cool to touch. Staff notified the physician.

Observation on 12-9-13 at 3:31 P.M. revealed the resident ambulated in the hall independently. The resident stated he was hungry and staff provided a snack for the resident.

On 12-10-13 at 8:04 A.M. observation revealed the resident wandered up and down the halls and wandered in and out of other residents rooms.

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{F 323}	Continued From page 12 On 12-11-13 at 9:31 A.M. observation revealed the resident wandered up and down the halls in and out of residents' rooms. On 12-11-13 at 10:08 A.M. direct care staff R stated he/she worked in the facility the day the resident eloped. He/she stated he/she normally carried a pager, but the facility was short several pagers so he/she did not have a pager that day. On 12-11-13 at 3:59 P.M. direct care staff P stated he/she worked in the facility the day the resident eloped from the facility and carried a pager, but it did not alarm or display letting him/her know the Assisted Living door alarmed. On 12-10-13 at 4:50 P.M. administrative nurse D stated the door alarm sounded on Assisted Living and staff responded, looked for a resident and did not see any residents in the vicinity. In the mean time, other staff started accounting for the residents' to determine who may have exited through the door. A person from across the street came to the facility and said a person was by a truck across the street and staff found the resident behind a building across the street from the facility. Administrative nurse D stated the charge nurse's pager did not alarm him/her the Assisted Living door opened and Information Technology (IT) staff checked the system and was not able to find a malfunction in the system. He/she stated the charge nurse and certified nursing assistants (CNAs) carried pagers. On 12-11-13 at 9:46 A.M. IT staff FF checked each exit door with the pager and each door alarmed and displayed which exit door was activated. He/she stated nursing monitored the	{F 323}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 13 pager system weekly. On 12-11-13 at approximately 2:30 P.M. licensed staff I stated the facility had 7 pagers but 2 pagers were not functioning that day, so 5 staff carried a pager. He/she stated staff checked the doors weekly; before the elopement staff checked the doors randomly. He/she stated the facility did not document when the doors were checked. On 12-11-13 at 4:55 P.M. licensed nurse J stated he/she was the charge nurse the day the resident eloped and his/her pager did not display or sound that the Assisted Living door was activated. The 12-11-13 Elopement Risk Assessment and Safety Policy documented staff ensured the safety of each resident admitted to the facility to avoid elopement. The policy documented staff checked the doors weekly and documented it. The facility failed to ensure this severely cognitively impaired resident's safety when he/she eloped from the facility and failed to monitor the exit doors and pager system weekly to ensure they functioned properly.	{F 323}		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	R 12/13/2013

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F 425	Continued From page 14 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This Requirement is not met as evidenced by: The facility identified a census of 34 residents. The sample included 10 residents. The facility identified 12 cognitively impaired independently mobile residents in the facility. Based on observation and interview the facility failed to administer prescription medications in a safe manner for 1 resident. (#20) Findings included: - Resident #20's significant change Minimum Data Set 3.0 Assessment (MDS) dated 10-3-13, documented the resident's Brief Interview for Mental Status score (BIMS) was 2, which indicated the resident had severe cognitive impairment. The MDS documented the resident was independent with bed mobility, toileting, and personal hygiene. The resident required extensive assistance with activities of daily living (ADLs) for ambulation,and locomotion. Observation on 12-10-13 at 12:41 P.M. revealed the resident was in bed and lying on his/her back on his/her bed. The resident's eyes were closed and did not respond to verbal greetings. The resident had approximately 5 pills in an open container on his/her bedside table.	F 425		

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F 425	Continued From page 15 On 12-10-13 at 4:26 P.M. during staff interview, direct care staff O stated the resident refused to take medications when staff brought them into the room and always requested staff leave them on the over bed table. He/she stated he/she observed the resident from the doorway to make sure he/she took the medication and often stood 30-45 minutes before the resident took his/her pills independently. On 12-10-13 at 12:43 P.M. administrative licensed nurse D stated the resident needed to be re-assessed to take medications independently and acknowledged cognitively impaired independently mobile residents had access to the medications and they should not be left in the room. On 12-11-13 at 2:41 P.M. during interview, licensed nurse H stated the resident often refused medication from the staff, would pick out the medications he/she wanted to take and left the others. He/she reviewed the resident's record and stated staff did not notify the physician the resident refused his/her medication on a regular basis. The facility failed to administer prescribed medications in a safe manner to the resident.	F 425		
{F 441} SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	{F 441}		

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{F 441}	Continued From page 16 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility identified a census of 34 residents. Based on observation, record review, and interview the facility failed to maintain a sanitary transfer of clean and soiled linens on 2 of 4 halls. Findings included: - On 12-10-13 at 7:31 A.M. observation revealed housekeeping staff X removed linens from a non-sampled resident and carried the linens	{F 441}		

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{F 441}	Continued From page 17 against his/her body and placed the linens in a container in the hall way. He/she picked up clean linens and carried them against his/her clothing into the resident's room. On 12-10-13 at 7:36 A.M. observation revealed housekeeping staff Y cleaned a resident's room and came into the hall, picked up the clean linens and carried them against his/her body into an unsampled resident's room. On 12-10-13 at 9:02 A.M. observation revealed housekeeping staff X removed linens from an unsampled resident's bed and placed the linens on the floor. Housekeeping staff placed clean linens on the resident's bed, and placed the linens on the floor into a yellow trash bag, placed the bag into a container and took the container to a utility room. Record review on 11-21-13 revealed housekeeping staff X and Y attended an Infection Control inservice that addressed disposition of soiled linens. On 12-11-13 at 2:12 P.M. licensed nurse I stated staff should not carry clean or soiled linens against their body and should not have placed linens on the floor. The facility failed to transport clean and soiled linens in a sanitary manner.	{F 441}		